



Message from the Alliance for Retired Americans Leaders

NIRS Report Examines the Impact of Switching Away from Defined Benefit Pension Plans



Robert Roach, Jr.
President, ARA

The National Institute on Retirement Security (NIRS) has released a new **report** tracking the experience of five states –

Alaska, Kentucky, Michigan, Oklahoma, and West Virginia – after new public sector employees’ were given defined contribution retirement plans rather than traditional pensions.

A significant number of defined contribution or 401(k)-type plans are cashed out when workers leave public sector jobs, and often these funds are not saved for retirement.

As for the states, their costs have not improved since the switch, either. In some of the studied states, poor funding practices were in place before the pension plan closure, and after improved funding practices were instated later, costs remained high. Closing pension plans for new employees has failed to address funding shortfalls and contributed to increased employee turnover.

“Defined benefit pension plans increased retirement security for workers, plain and simple,” said **Robert Roach, Jr., President of the Alliance**. “The data show that no one benefited when these states decided to take away the pensions public sector workers relied on for decades.”

Administration Announces Plans to Seize

Patents for Certain High-Priced Medicines



Rich Fiesta,
Executive
Director, ARA

The Biden Administration continues to take action to lower drug prices and boost competition. On Thursday it announced a new plan to use ‘march-in’ rights to seize patents for medicines that were developed with taxpayer dollars in order to bring down costs for the most expensive drugs. The move could also open the door to a more aggressive federal campaign to slash drug prices.

March-in rights have never been utilized by the federal government before. Health care advocates have urged seizing patents as a way to lower prescription drug costs and allow the government to share in the profits derived from federally-funded drug research.

The march-in policy derives from the University and Small Business Patent Procedures Act of 1980, known as the Bayh-Dole Act. This allows recipients of federal research funding to retain rights on inventions, except in cases where federal agencies choose to “march-in.” That can occur when there are circumstances that concern expanding accessibility, national health, and safety. The administration is using the Bayh-Dole Act as a basis for its action.

“The Alliance welcomes the Biden Administration’s latest decision to lower prescription drug prices by using all the tools at their disposal,” said **Richard**

Fiesta, Executive Director of the Alliance. “Taxpayers should get a share in the massive profits that pharmaceutical corporations have raked in as a result of government research.”

KFF Report: Qualified Medicaid Beneficiaries Wait 36 Months to Receive Home and Community Based Services on Average



Joseph Peters
ARA
Sec.-Trea.

Home- and community-based services (HCBS) waivers allow states to offer a wide range of Medicaid benefits to residents with low-incomes or disabilities and to choose the number of people who receive services. However, these waivers also allow states to cap the number of people enrolled in their waiver program.

This can result in waiting lists when the number of people seeking services exceeds the number of waiver slots available, according to a **KFF report** that covers 2016-2023. The average wait time in 2023 has been 36 months, which is down significantly from 45 months in 2021. Waiting lists reflect the populations a state chooses to serve, the services it decides to provide, the resources it commits, and the **availability of workers** to provide services. For coverage of Long-Term Services and Supports (LTSS) under Medicaid such as home health, people must meet **state-specific eligibility requirements** regarding their levels of income,

wealth, and functional limitations.

The only HCBS that states are required to cover is home health. However, states may choose to cover personal care and other services such as private duty nursing through the Medicaid state plan. States may also use HCBS waivers to provide services such as adult day care, supported employment, and non-medical transportation.

Since 2016, in the states where waivers are offered, there has been an annual average of 700,000 people nationwide on waiting lists. People with intellectual or developmental disabilities are forced to wait 45 months longer than seniors and 13 months longer than those with autism. Although waivers take a long time to be processed, most people are eligible for other types of HCBS while waiting. 0

The delay is attributed to states underfunding the program as well as a shortage of qualified employees to provide the services since the Covid pandemic.

“Those who are eligible for Medicaid services have a real and immediate need and should not have to wait,” said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. “The American Rescue Plan will likely prove highly beneficial when that data becomes available. Congress should also acknowledge the regrettable waitlist data for home- and community-based service waivers and further expand funding.”

Medicare Advantage Plans Disadvantage Many Elderly and Disabled People

For-profit Medicare Advantage program restrictions routinely result in delays and the denial of necessary health care.

When retired veterinarian Richard Timmins went on a Medicare Advantage plan in 2016, he admits that he knew very little about Traditional Medicare (also called Original Medicare) or the more than 3,800 Medicare Advantage plans that are marketed to seniors and the disabled.

“I went to a so-called Medicare Information Session and took the recommendation of the speaker and ran with it,” Timmins told *Truthout*. “I did not know that he was paid a commission for every person he signed up for

a plan. The issue for me was cost.”

Like other Medicare beneficiaries, Timmins knew that the standard premium for Medicare coverage — \$164 per month in 2023 — would be taken out of his monthly Social Security checks. He also understood that there would be a \$226 annual deductible for Part B, which covers doctor’s visits, but after that deductible was met, Traditional Medicare would pick up 80 percent of the cost of his care. What’s more, he knew that dental, optical and audiology were not covered by the plan and that he would be responsible for paying the remainder of his health care costs — 20 percent of



the total — out of pocket unless he purchased a separate, costly Medigap insurance plan.

Not surprisingly, when Medicare Advantage promised broader coverage for less money — the same deduction would be taken from his Social Security check, but he would not need a supplemental Medigap plan since Medicare Advantage (sometimes referred to as Plan C) would provide coverage for most of the services that Traditional Medicare did not offer — Timmins quickly signed up.

That’s when his nightmare began. After his primary care physician noticed a lump in his ear, Timmins was told that he

needed to see a dermatologist. “I have a family history of skin cancer, so I tried to make an appointment right away but was told that I needed prior approval from my insurer to see the specialist,” he said. “It took seven months to get this approval and, in that time, the growth tripled in size and became painful. I finally had surgery to remove it in 2022. Had I been on Traditional Medicare, I would have quickly seen the dermatologist and the oncologist since prior approval is not required. I would have had the lump removed when it was smaller, before it extended into the tissue.”...[Read More](#)

Medicare Is in Desperate Need of Modernization and Expansion — Not Privatization

Monetizing Medicare and Medicaid undermines coverage for those who need it most.

For 58 years, Medicare and Medicaid have provided life-saving and life-sustaining care for millions of Americans, but they are rapidly being weakened by politicians who insist on inviting corporations to oversee their implementation.

Health insurance companies are creeping into Medicare and Medicaid via so-called “managed care.” Often proposed as a cost-saving measure, managed care is when patients agree to visit only certain doctors and hospitals, and the cost of treatment is monitored by a managing company. Here in the United States, these companies are often corporations focused on maximizing profit at the expense of patients.

Gary Bent — a man who spent his entire life faithfully paying into Medicare — was just one of the millions of patients who have been denied crucial care because of corporate intrusion into the administration of Medicare benefits.

When Bent finally became eligible for the Medicare benefits he paid into, his employer placed him on a Medicare Advantage plan — a plan administered by a private health insurance company, rather than on a traditional government-administered Medicare plan. But in 2022, when Gary was diagnosed with melanoma for the

second time, prior-authorization denials led to delays in getting the rehabilitation services and skilled nursing care he needed. He died March 3, 2023, of complications due to melanoma.

“It has been hard for me not to dwell on how things might have been different for my father, for our family, if my dad had just received the care he needed when he needed it,” said Bent’s daughter, Megan Bent, as she spoke to a small crowd gathered in front of the United States Capitol to commemorate the 58th anniversary of Medicare on July 25, 2023.

“My father was dedicated to creating change, doing what he could to make the world a better place,” Bent added. “I remember coming to D.C. to protest apartheid with him when I was kid, and I know that being here today and sharing our story, his story, is a way to continue his legacy and to continue to fight for him.”

Medicare and Medicaid are widely accessed public benefits programs in the U.S., with Medicare serving nearly 57 million older adults and Medicaid serving 87 million low-income, pregnant people and children. Yet despite the resounding popularity of these taxpayer-funded programs, politicians continue inviting profit-obsessed corporations into the



implementation of these program.

Medicare Advantage plans offered by private health insurers now cover more than 50 percent of all Medicare recipients at a cost to taxpayers of more than \$400 billion a year. Health insurance companies are also creeping into Medicaid via so-called “managed care” (i.e. managed denials). Late last month, the U.S. Department of Health and Human Services (HHS) Office of Inspector General released a report that showed that 25 percent of the claims for Medicaid beneficiaries are denied by private insurers via managed care. To make matters worse, private equity firms are buying up nursing homes, and home care agencies are joining insurance companies in gouging public programs, causing older and disabled Americans to bear the cost.

Monetizing these programs flies in the face of the intent of Medicare and Medicaid and undermines the promises of coverage for those who need it most. Corporations beholden to quarterly profit margins and shareholders — not taxpayers or patients — have focused on increasing profit margins through two key strategies: overcharging the government while trimming costs by limiting the services they cover and paying care workers less; and denying and delaying care people need.

Corporate insurers offering Medicare Advantage plans are estimated to be **overbilling the federal government by up to \$75 billion a year**, while routinely and pervasively denying and delaying care for older adults and disabled people on their plans. At least **2 million prior authorizations** were denied by Medicare Advantage plans in 2021 alone. Yet despite all the hazards of Medicare Advantage, many people are lured into these plans through the promise of lower premium costs and because traditional Medicare fails to cover vision and dental care.

At the same time, private equity firms are joining insurance companies to profit off people at Medicare and Medicaid’s expense. Between 2000 and 2018, **private equity’s stake in nursing homes grew from \$5 billion to \$100 billion**. Private equity ownership accounted for **half of the deals in the home care industry in 2018 and 2019**, and its stake in the hospice field has grown by 25 percent between 2011 and 2020. The results are **disastrous**: layoffs and staff reductions, limitations of services, higher risks and worsening care outcomes. Patients in nonprofit hospice care see physicians **three times more often than patients in for-profit hospices**. ...[Read More](#)

Social Security Clawbacks Hit a Million More People Than Agency Chief Told Congress

The Social Security Administration has demanded money back from more than 2 million people a year — more than twice as many people as the head of the agency **disclosed at an October congressional hearing.**

That's according to a document KFF Health News and Cox Media Group obtained through a Freedom of Information Act request.

Acting Commissioner of the Social Security Administration Kilolo Kijakazi read aloud from the document during the hearing but repeatedly left out an entire category of beneficiaries displayed on the paper as well.

The document indicates the fallout from Social Security overpayments and clawbacks is much wider than Kijakazi acknowledged under direct questioning from a House Ways and Means subcommittee that oversees the federal agency.

In a statement for this article,

SSA spokesperson Nicole Tiggemann described the numbers of people Kijakazi provided in her testimony and those she left out as “unverified.”

“We cannot confirm the accuracy of the information, and we have informed the committee,” Tiggemann said.

The numbers “were gathered quickly,” the spokesperson said. Social Security systems “were not designed to easily determine this information,” she said.

After the October hearing, KFF Health News and Cox Media Group sent Tiggemann several emails asking her to clarify whether the annual numbers Kijakazi gave to Congress included all Social Security programs or just a subset. She would not say.

For answers, the news organizations several weeks ago filed a FOIA request.

Rep. Greg Steube (R-Fla.), a member of the subcommittee,



said in an interview that he wondered if the agency “intentionally deflated the numbers to not make it look as bad as it is.”

“Maybe we should have her come back in for another hearing, put her under oath,” and ask her “why she wasn’t being completely upfront about the numbers,” Steube said.

Steube said that, when he heard Kijakazi’s testimony, he thought she was giving the subcommittee the complete numbers.

At issue is the scope of a **problem that has terrified** many Social Security beneficiaries and plunged them into financial distress.

As KFF Health News and Cox Media Group television stations jointly reported in September, the government has been **trying to recover billions** of dollars from beneficiaries it says it overpaid. In many cases, the overpayments were the government’s fault.

But, even in cases where the beneficiary failed to comply with requirements, years can pass before the government catches the mistake and sends a notice demanding repayment, often within 30 days. In the meantime, the amount the beneficiary owes the government can grow to tens of thousands of dollars or more — far more than people living month to month could likely repay.

The people affected may be retired, disabled, or struggling to get by on only minimal income.

The number of people experiencing overpayments is important to know because overpayments can cause a lot of harm, said Kathleen Romig of the **Center on Budget and Policy Priorities**, who worked in research at the Social Security Administration and has since spent 20 years in the field of Social Security policy....**Read More**

Social Security Rules Could Result in Pension-Eligible Recipients Having Benefits Taken Back — How To Plan for Overpayments

Americans who receive pensions have a complicated relationship with the **Social Security system** due to a couple of federal rules designed to reduce excessive Social Security payouts: the Windfall Elimination Provision (WEP) and Government Pension Offset (GPO). Both restrict Social Security benefits for public-sector pensioners — and in some cases, people have even had **benefits taken away.**

That was the case with Joyce Debnam, an 80-year-old Maryland woman who received \$1,400 a month in Social Security **survivor benefits** following the death of her husband.

As CNBC recently reported, when Debnam retired from the U.S. Postal Service after 40 years there, her Social Security check was suddenly slashed to \$174 a month — and she was told by the Social Security Administration that she owed \$5,000 in overpaid benefits.

The reason all this happened is because Debnam receives a government pension from her

USPS career. Many government workers are not covered by Social Security because they don’t pay Social Security payroll taxes on their earnings or get credit for that work when the SSA calculates their benefits.

The WEP and GPO provisions outline how Social Security deals with retirees who receive pensions. Under the WEP, Social Security benefits are reduced if you receive a pension from work, did not pay into Social Security, and had fewer than 30 years of “substantial” employment or covered employment, CNBC noted.

The Congressional Research Service estimates that as of December 2022, about 2 million people, or 3% of all Social Security beneficiaries, were affected by the WEP.

The Government Pension Offset affects spouses, widows and widowers who receive government pensions and in some cases reduces their Social Security benefits, according to the SSA. If you receive a pension from a government job but didn’t



pay Social Security taxes while you had the job, the SSA will reduce your Social Security spouse, widow or widower benefits by two-thirds of the amount of your government pension.

As of December 2022, nearly 735,000 Social Security beneficiaries, or roughly 1% of all beneficiaries, had their benefits reduced by the GPO. Of those directly affected by the GPO, 52% were spouses and 48% were widow(er)s, according to the Congressional Research Service. About 70% of all GPO-affected beneficiaries had their benefits fully offset, while 30% had their benefits partially offset.

To address the problem, lawmakers earlier this year reintroduced the bipartisan *Social Security Fairness Act*, which aims to repeal the WEP and GPO. The bill has “broad bipartisan support among 300 lawmakers” in the U.S. House, according to Reps. Abigail Spanberger (D-Va.) and Garret Graves (R-La.), who are leading efforts to get the Act passed.

In the meantime, pensioners can take steps to prepare for the possibility of **Social Security overpayments.**

As CNBC noted, the SSA provides a supplemental fact sheet about the WEP and GPO rules to workers with five or more years of noncovered earnings. The agency doesn’t calculate the altered retirement benefit to adjust for that income, but you can do it yourself using **WEP** and **GPO online calculators.**

In addition, the SSA recommends reviewing your Social Security statement at least once a year to find information about the WEP and GPO. To learn more about how to get a Social Security statement, visit **this SSA site.**

NOTE: The Bill mentioned in this article is H. R. 82. There is a National Task Force that has been pushing to repeal the WEP/GPO for two years. There is a Petition that now has over 111,500 signers.

For more information on the National Task Force visit **ssfairness.org**

For-Profit Hospices Often Aim for Return on Investment, Not Death With Dignity

Easy access to Medicare dollars without medical training has made hospice attractive to investors and con artists.

It was something of a radical idea: that the terminally ill deserve a guide to shepherd them peacefully through life's final transit, and that a special care service might help confront the ubiquitous anguish of death. Hospice is an ancient Roman Catholic tradition, but in its recognizably modern form, it dates only to the 1960s.

From the beginning, hospice was as much an ethos as a health care job. The earliest providers were uniformly nonprofit endeavors. With the 1982 advent of full Medicare reimbursement, hospice came to provide exceptional and humane end-of-life ministrations, with nurses and counselors prepared for everything from palliative care to bereavement support to spiritual advice for families.

Yet in the last two decades, at

first slowly and then in an onslaught, the field of hospice has been transformed. An influx of for-profit

operations, drawn to potentially vast profit margins, dominates the field. Now, in some corners, cost-cutting and profiteering are the order of the day, with direct consequences for patients. And of course, Medicare, the public dollar, is underwriting their extraordinary returns.

There are well-operated, humane for-profit hospices, to be sure. But for the more cynical operators — and there are many — compassion, and a peaceful and dignified death, are no longer the care standards; the aim is profit alone.

Radical Compassion

The National Partnership for Healthcare and Hospice Innovation (NPHI) is a membership organization of nonprofit U.S. hospices, where Larry Atkins is chief policy



officer. Forty years ago, “This was a social movement, and not a part of the Medicare program,” Atkins

told *Truthout*. “We were all nonprofit

The pioneers of hospice saw an opportunity to revolutionize the end-of-life care of the time. Before hospice was widespread, patients often died in an intensive care unit (ICU), on a ventilator, perhaps alone. Last-ditch efforts to prolong their lives could be as punishing as they were futile, ultimately snatching back only a brief span of time, marked only by more suffering. More pragmatically, pointed out Atkins, “People dying in the ICU can be extremely expensive. Really if there was nothing that could be done, it was quite wasteful, and quite intensive and invasive for the individual. The idea was that we could both humanize the

experience and save Medicare money.”

To this day, hospice remains a paragon of humane medicine — treating not only a patient's ailments but their psyche, and that of their family as well. In fact, many established hospices maintain ties that assist healing across entire communities. *Truthout* reached Rico Marcelli, communications director at **Hospice East Bay** in California, who spoke to hospices' deep local roots and public ethos...

Hospice East Bay operates Bruns House, the only inpatient hospice unit in the Bay Area, which provides round-the-clock care to assist people and their families in passing peacefully. Operating Bruns House costs a million dollars a year, noted Marcelli. But the nonprofit doesn't bemoan the expense. Its benefit to the community has been incalculable, he said. **[Read More](#)**

These are the most important changes to Social Security for 2024

The year is about to end and it is the best time to take into account and prepare for the **changes in Social Security** that will take effect next year, as **these could affect your monthly benefits**.

Both the program and payments are affected each year by some factors, including the cost of living adjustment (COLA), Medicare premiums, and maximum taxable income, which may **increase or decrease the amount that a beneficiary receives each month**.

These are the most important changes to Social Security for 2024. Cost of Living Adjustment (COLA)

Every year in October, the Social Security Administration calculates the cost of living adjustment (COLA), which represents an increase to monthly payments. The COLA is calculated for benefits to keep up with inflation and to avoid affecting the purchasing power of beneficiaries.

The COLA is linked to the annual increase in the Consumer Price Index for Urban Wage

Workers and Clerical Workers (CPI-W). The SSA takes into account the CPI-W data from the third quarter of the previous year and compares it with that of the third quarter of the current year and if there has been an increase, the SSA increases the benefits. **The COLA for 2024 is 3.2%.**

New payment amounts
Thanks to the COLA, monthly payments will increase by 3.2%. This year, the average payments for all retired workers have been \$1,848, according to the SSA. **With a 3.2% increase they would be \$1,907 in 2024.**

Meanwhile, **the average payments for elderly couples, where both receive benefits, have been \$2,939. With the COLA they would increase to around \$3,033.**

In the case of Supplemental Security Income (SSI), the standard federal payment will increase from \$914 to \$943 for individuals and from \$1,371 to \$1,415 for couples. Other Social Security payments would look



like this for 2024, according to the SSA:

- Surviving spouse with two children: from \$3,540 to \$3,653
 - Single elderly surviving spouse: from \$1,718 to \$1,773
 - Worker with a disability, his or her spouse, and one or more children: from \$2,636 to \$2,720
- All workers with a disability: from \$1,489 to \$1,537**

Maximum payment amounts
The maximum benefit for those who retire at their full retirement age will be \$3,822 per month. This amount does not depend on the COLA.

Full retirement age is the age recommended by the SSA to receive full Social Security payments, that is, 100% of what each retired worker is entitled to.

The full retirement age depends on the worker's year of birth. If he or she was born between 1943 and 1954, it is 66 years old. If you were born between 1955 and 1959, the full retirement age gradually increases until it reaches age 67 for those born from 1960

onwards.

Maximum taxable payment increases

To receive the maximum monthly payment, you must meet certain criteria. One of them is that you must pay Social Security payroll taxes on the maximum taxable income in your 35 highest-earning years.

Like the COLA, the taxable income limits change each year. This amount is linked to the national average salary index, so it tends to increase from one year to the next. In 2023, only the first \$160,200 have been subject to these taxes. In 2024, **the maximum income will be \$168,600, meaning more of a worker's income will be subject to the tax.**

Medicare Part B Premium
Social Security benefits are affected by Medicare, as the Part B premium is deducted from monthly checks. Medicare Part B monthly premiums will increase to **\$174.70 in 2024. The annual deductible will be \$240 next year.**

Watch: The Long-Term Care Crisis: Why Few Can Afford to Grow Old in America

For many in America, especially people in the middle class, old age is a daily struggle to keep up with basic activities. For some, the trials of dementia add to the emotional and financial burden for loved ones and caregivers. Long-term care

options — assisted living, home care, or full-time family care — are costly, complex, and often inadequate.

Jordan Rau, KFF Health News senior correspondent, moderated



a Zoom event Dec. 5 about “Dying Broke,” an investigative project undertaken with The New York Times and Times reporter Reed Abelson about America’s long-term care crisis.

Panelists shared their lived experiences of caregiving.

The event was hosted by KFF Health News and the John A. Hartford Foundation.

[Watch the video here](#)

11 Signs Your Aging Parent Needs Senior Care

It can be difficult to determine when your aging parent can no longer live alone. Learn the signs to look for and steps to take to ensure their safety.

Aging is a fact of life, and many older adults may reach a point when they can no longer look after themselves. Often, their adult children are left to determine when that time comes – a challenging prospect for everyone involved.

However, experts have identified a number of signs for adult children to note.

In this guide, we'll list those signs, give you questions to ask and provide guidance for how to approach the topic of extra care for your parents.

Warning Signs

Changes to or developing new behaviors might indicate your parent needs more assistance, says Dr. Paul Chiang, medical director of Northwestern

Medicine HomeCare Physicians in Wheaton, Illinois, who makes house calls to homebound seniors.

Specific questions to ask and warning signs to look for include:

- ◆ [Is your loved one able to manage self-care?](#)
- ◆ [Is there significant memory loss?](#)
- ◆ [Is your elderly loved one safe in the home?](#)
- ◆ [Is your loved one safe driving a car?](#)
- ◆ [Has your loved one lost weight?](#)
- ◆ [Has your elderly loved one's mood or spirit changed?](#)
- ◆ [Have your loved one's sleeping habits changed?](#)
- ◆ [Is your loved one socially active?](#)
- ◆ [Is your elderly loved one walking safely and steadily?](#)



◆ [Is your loved one able to manage their household and finances?](#)

◆ [Is your loved one able to manage their medical conditions and medication schedule?](#)

[Is your loved one able to manage self-care?](#)

Adult children of aging parents need to “be a detective when visiting the aging parent,” says Jennifer Avila, executive director of Custom Home Care, a home services and home nursing agency in the Chicago area.

For instance, she recommends looking in the refrigerator for clues – like old, expired or a lack of food – that your parent might not be caring for themselves properly.

Personal hygiene can also be a strong indicator that your parent needs more help. Some older adults may begin to have difficulty showering regularly,

washing their clothes and cleaning their living space, says Chiang, who also works for the Home Centered Care Institute, a nonprofit whose mission is to bring house-call medicine to complex patients across the country.

[Is there significant memory loss?](#)

One red flag to watch out for is increasing forgetfulness and confusion.

“(Not) everyday memory lapses, such as misplacing one’s keys, but rather not being able to find their way home from the grocery store,” says Dr. Elizabeth Landsverk, a geriatrician based in the San Francisco area.

Finding your parent wandering outside with little idea of how or why they got there is a warning sign to keep an eye out for... [Read More](#)

Some Medicare prescription drug plans dropping insulin coverage

One of the many design and structural defects of the Medicare Part D prescription drug benefit is that the health insurers offering coverage have enormous latitude to determine the drugs they will cover. Not only does that mean the insurers might not cover some basic generic drugs, it means that they might cover some drugs today and different drugs tomorrow. With a recent legal requirement that limits out-of-pocket costs for people with Medicare using insulin, Medora Lee reports for [USA Today](#) that some Part D prescription drug plans are dropping coverage of insulin.

Because insurers cannot charge people with diabetes more than \$35 a month for each insulin product they take, Part D insurers might be able to keep down premiums and attract healthier

members by dropping insulin coverage. They also likely project greater profits if they do not cover insulin. So, anyone with Medicare in need of insulin better beware.

You should check to ensure that your Part D prescription drug coverage will pay for the insulin you take in 2024. If not, you should switch to a different Part D plan if you can. Keep in mind that your Part D plan can change the drugs it covers at any time, however, if it does, you generally have a right to coverage of your medically necessary drug throughout the rest of the year if you have no alternative.

It’s a travesty that Part D insurers can game the Medicare system to the detriment of people with diabetes. It’s equally problematic that they can



game the system to hurt people with all different sorts of prescription drug needs. For example, [CVS was found not to have generic versions of some](#)

[drugs on its Part D formulary](#); it profited more from only having the brand-name drugs, for which it received rebates and otherwise benefited financially.

It’s also deeply concerning that Part D insurers can charge [higher copays for some drugs than Costco charges for the full cost of the same drugs](#). One Just Care reader reported that to keep his costs down, he had to get his drugs from different sources. Costco had lower prices for some drugs and his Part D plan had lower costs for others.

In 2025, people with Part D will not pay more than \$2,000 out of pocket for drugs their insurer

covers. That’s the good news. I’m willing to bet that the Part D insurers find a way to take advantage of this new consumer protection, while making it harder for their members to get the drugs they need.

Congress should come to its senses and establish one prescription drug benefit that meets everyone’s needs. It should not allow Part D plans to meet only some prescription drug needs. Right now, the Medicare Part D benefit is designed to line the pockets of insurance companies and pharmacy benefit managers not to bring down drug costs as much as possible for people with Medicare or to ensure that their Part D coverage meets their current and future prescription needs.

New Rules Expand Medicare Dental Coverage for Some

While Medicare dental coverage remains extremely limited, the **2023** and **2024** Medicare Physician Fee Schedule (PFS) final rules expand access in certain situations. A new **KFF issue brief** offers context for these updates and describes how they may impact people with Medicare.

The **Medicare statute** is generally read as excluding from coverage all services “in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.” However, the law creates an exception, allowing Medicare to pay for dental services in certain limited situations, including trauma and where the removal of a tooth is required in order for successful treatment of a cancerous tumor in the jaw, and to cover care in inpatient settings “if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.”

Historically, the Centers for Medicare & Medicaid Services (CMS) has narrowly interpreted this language, only covering medically necessary **dental treatment** in highly specific instances. **Medicare Rights and**

other advocates have long urged a different approach, asserting the statute permits the agency to go further, and that not doing so unnecessarily restricted beneficiary access to care.

In response to these and other **similar concerns**, in the 2023 and 2024 PFS rules, CMS clarified and expanded Medicare coverage of medically necessary dental treatment in the following ways:

The 2023 final rule outlined the criteria for Medicare Part A and B coverage of medically necessary dental services. Medicare will now pay for dental services “that are inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services” in both inpatient and outpatient settings. In other words, when the dental treatment is linked to the clinical success of another, Medicare-covered, service. The services must be integrated, “meaning medical and dental professionals must coordinate care.” CMS also finalized a change allowing Medicare to pay for “ancillary services that are critical to the success of dental services, such as X-rays, administration of anesthesia, and use of an operating room.”

The 2023 and 2024 final rules defined new clinical scenarios in which Medicare



can pay for dental services. Using this coverage criteria, in the 2023 final rule CMS codified a wider range of circumstances in which Medicare can pay for medically necessary dental services, such as prior to organ transplants, cardiac valve replacements, and head and neck cancer treatments. The 2024 final rule enumerated additional expansions, ensuring Medicare can address oral health complications that occur after the treatment of head and neck cancers, and for people undergoing certain cancer-related chemotherapy, radiation, and cell therapies. CMS also signaled openness to other instances in which medically necessary dental coverage may be required, noting plans to use the annual PFS rulemaking process to socialize those proposals.

These reforms will help mitigate some of the barriers to dental care that people with Medicare can face, improving health outcomes and quality of life for many. According to KFF, “CMS estimates that approximately 190,000 additional dental services could be covered by Medicare prior to organ transplants, cardiac valve replacement, valvuloplasty procedures beginning in 2023” and “an additional 155,000 beneficiaries” might receive

dental services relating to cancer treatments under the coverage that starts next year.

Medicare Rights applauds these policies, which take vital steps toward integrating oral health into whole-body health. While we remain committed to expanding medically necessary dental coverage, we also recognize the need to embed more broadly available services into the program. Accordingly, we will also continue to advocate for the addition of a **comprehensive dental benefit** to Medicare Part B. Absent such a change, millions of older adults and people with disabilities will continue to **lack access** to affordable, essential dental services. The evidence is clear that such care is **critically important** to maintaining overall health, and that Medicare’s coverage gap exacerbates racial, geographic, and disability-related health and economic disparities and inequities. We urge Congress and the administration to work together to bolster core Medicare oral health coverage, without delay.

Read the KFF report, “**Recent Changes to Medicare Coverage of Dental Services from the 2023 and 2024 Medicare Physician Fee Schedule Final Rules.**”

House Passes New Veterans’ Nursing Home Care Alternative Bill

The House of Representatives has passed bi-partisan legislation, H.R.542 - *Elizabeth Dole Home Care Act of 2023*, that addresses home care and caregiver programs provided by the Department of Veterans Affairs (VA).

Under the bill, the cost of providing noninstitutional alternatives to nursing home care generally may not exceed 100% of the cost that would have been incurred if a veteran had been furnished VA nursing home care. (Under current law, these expenditures are limited to 65% of the cost.)

However, for specified

veterans, the VA may exceed 100% of the cost if it determines the higher cost is in the best interest of such veterans (i.e., veterans with

amyotrophic lateral sclerosis, a spinal cord injury, or a condition the Secretary determines to be similar to such conditions).

The *Elizabeth Dole Home Care Act* would expand the VA’s Home and Community Based Services (HCBS) to all Department of Veterans Affairs (VA) Medical Centers (VAMC), ensuring that veterans who need home care can receive it and avoid costly nursing home care.



It will also improve the VA’s care coordination and outreach to better connect veterans and their caregivers with critical services and support.

The bill directly addresses the need for improved home care by expanding existing home- and community-based services so that veterans needing institutional care, which is costly and often isolating, can be delayed or prevented. When veterans can stay in their homes, families can stay together, caregivers have the support they need,

and veterans remain connected to their communities.

About 50% of veterans in the US are age 65 or older. Many veterans are opting to age at home instead of seeking long-term institutional care, with an estimated 5.5 million military and veteran caregivers in the US in 2014, according to a March 29 testimony on the measure from the Elizabeth Dole Foundation, a nonprofit supporting military caregivers.

The bill now goes to the Senate for consideration.

White House Could Punish Big Pharma's High Prices by Removing Patents

The Biden administration is flexing some federal muscle in its push for lower drug prices, warning pharmaceutical companies that it might use its authority to cancel patent protections if a medication costs too much.

Federal law allows the government to grant patent licenses if taxpayer dollars were used in the development of inventions -- including drugs.

In a **statement** released Thursday, the White House said it will consider granting patents to rival pharma companies if a drug becomes prohibitively expensive.

It's the first time that federal officials have been allowed to consider a drug's price in deciding to break patent protection.

"We'll make it clear that when drug companies won't sell taxpayer-funded drugs at reasonable prices, we will be prepared to allow other

companies to provide those drugs for less," White House National Economic Advisor Lael Brainard said during a call with reporters on Wednesday, *CNBC* reported.

This power over patents, called "march-in rights," were established under the Bayh-Dole Act of 1980 but they have never been exercised by any federal agency, administration officials told *CNBC*.

President Joe Biden promised that the move will lower drug prices for average Americans.

"Today, we're taking a very important step toward ending price gouging so you don't have to pay more for the medicine you need," Biden said in a brief YouTube video released Wednesday.

There will be a 60-day public comment period on the administration's plan, which is certain to be challenged by drugmakers.



Industry lobbying firm Pharmaceutical Research and Manufacturers of America (PhRMA) told the *Associated Press* that the plan could threaten the development of future drugs.

"This would be yet another loss for American patients who rely on public-private sector collaboration to advance new treatments and cures," PhRMA spokesperson **Megan Van Etten** told the *AP*.

Pharmaceutical companies often base new drug development on research that was first funded by federal dollars, experts said.

This patent threat could lead companies to avoid using federally funded research when investigating new therapies, PhRMA argued.

The assertion of "march-in rights" is part of a series of actions the administration announced Thursday aimed at anticompetitive practices in

health care.

Thursday's announcement noted that the 25 largest pharma companies currently control about 70% of industry revenues.

This consolidation also has affected health insurance. In 44 states, three or fewer health insurers control 80% of the market, and five insurers control more than 70% of the Medicare Advantage Market, the announcement said.

Other actions in the White House statement include:

- ◆ Launching a government investigation into how corporate consolidation is increasing the cost of health care.
- ◆ Increasing transparency on the ownership of hospitals, nursing homes and other health care facilities.
- ◆ Making it easier to obtain price and quality data from Medicare Advantage plans.

Critical home care is no longer affordable for most people and too often not available

Caring for an older person with multiple needs can take a toll physically, emotionally and financially. Reed Abelson reports for **The New York Times** on how reliable home care is hard to come by and not affordable over the long-term.

Frank Lee, the husband of one woman with dementia, was tending to his wife morning, noon and night. He ended up putting her in a respite program at an assisted living facility so he could take a short break. While he was away, she fractured her sacrum. Mr. Lee was at a loss to find home health aides he could trust, the plight of many older couples.

Eight million older adults suffer from dementia or need help with at least two activities of daily living, such as bathing and toileting. Only a small fraction of them—one million—have paid help outside a nursing home. Three million have no help.

Our federal government does little to help people who need home health aides. Medicare only covers **very limited home**

health health care and, then, only for people who are homebound and who need skilled nursing on an intermittent basis or skilled therapy. People with dementia don't usually fit these criteria. If you don't have Medicaid, you are generally out of luck in terms of government assistance and, even with Medicaid, there are often waitlists for home care.

Most older adults are cared for by family, not professionals. They cannot afford \$27 an hour, the going rate for a home care aide. Paying for fulltime home care usually means expenses of tens of thousands of dollars a year. Usually it is the older adult's spouse or daughter who takes on the role of caregiver.

People who can afford to pay for a caregiver often cannot find one with the skills to take care of their loved ones. They are often forced to hire untrained caregivers. Paid caregivers in the US rarely earn a living wage; they often can't count on fulltime work. And, they tend not to get health insurance benefits. It's no



wonder that there is a shortage of paid caregivers; they can get better jobs for the money. **What to do?** Plan ahead.

Talk to your loved ones about likely long-term care needs. Even if you have limited resources, it is better to be prepared. Most people do not have these conversations. Families are often unprepared. Many families cannot save enough to offset the cost of long-term care. But, if you plan ahead, you could qualify for Medicaid.

Keep in mind that long-term care needs can be extensive. Sometimes, two people are needed just to move someone from one place to another. Without assistance, simple tasks become huge burdens.

Mr. Lee wonders "What's the end game look like?" Is it right that he should watch his wife, who is already severely demented and unable to take care of herself or speak, deteriorate further? "As she disintegrates, I disintegrate." When people are terminally ill—six months or less of life—Medicare covers **hospice**

care, which covers some home care. But, good luck getting it if you're in a Medicare Advantage plan. And, even in traditional Medicare, finding an agency that will provide hospice care can sometimes be challenging.

Here's more

- ◆ **[Traditional Medicare offers better home care benefits than Medicare Advantage](#)**
- ◆ **[Need home health care? Don't count on Medicare](#)**
- ◆ **[Caregiving: Keeping Parents Healthy – Water, Walking, Watch out for Delirium](#)**
- ◆ **[Family caregiving: Costly, lonely and stressful work](#)**
- ◆ **[How to be a good long distance caregiver](#)**

As One Spouse's Blood Pressure Rises, So Does the Other's: Study

In sickness and in health -- and in blood pressure, too?

A new international study finds that if your blood pressure rises with time, your spouse's might, also.

"Many people know that high blood pressure is common in middle-aged and older adults, yet we were surprised to find that among many older couples, both husband and wife had high blood pressure in the U.S., England, China and India," said study senior author **Dr. Chihua Li**, a post-doctoral fellow at the University of Michigan.

"For instance, in the U.S., among more than 35% of couples who were ages 50 or older, both had high blood pressure," Li said in a news release from the American Heart Association (AHA).

Li's team published its findings Dec. 6 in the *Journal of the American Heart Association*.

High blood pressure is a common complaint among Americans, and the risk of hypertension rises with age. According to the AHA, almost half (about 47%) of adult Americans had high blood pressure in 2020, and it contributed to 120,000 deaths that year.

In the new study, Li and colleagues looked at rates of high blood pressure among nearly 34,000 heterosexual couples worldwide: 4,000 U.S. couples, 1,100 couples in England, more than 6,500 Chinese couples and over 22,000 Indian couples.

Data was collected between 2015 and 2019, depending on the country.

High blood pressure was defined as systolic (the upper number in a reading) blood pressure higher than 140 mm Hg or diastolic greater than 90 mm Hg, as measured by health



professionals. Study co-lead author **Jithin Sam Varghese** said the team

"wanted to find out if many married couples who often have the same interests, living environment, lifestyle habits and health outcomes may also share high blood pressure."

The research seemed to support that notion: "The prevalence of both spouses or partners having high blood pressure was about 47% in England; 38% in the U.S.; 21% in China and 20% in India," according to the AHA news release.

The results didn't seem to vary regardless of a couple's income, age, education or how long they'd been married.

"Ours is the first study examining the union of high blood pressure within couples from both high- and middle-income countries," noted

Varghese, an assistant research professor at the Emory Global Diabetes Research Center in Atlanta.

Fortunately, there are many things individuals *and* couples can do to avoid high blood pressure, one expert said.

"Making lifestyle changes, such as being more active, reducing stress or eating a healthier diet, can all reduce blood pressure; however, these changes may be difficult to achieve and, more importantly, sustain if your spouse or partner [and greater family unit] are not making changes with you,"

said **Bethany Barone Gibbs**, She's chair of the department of epidemiology and biostatistics at the School of Public Health at West Virginia University, and she also helped devise the AHA's recent guidelines on exercise and blood pressure.

Rheumatoid Arthritis Drug Could Put Brakes on Type 1 Diabetes

A drug long used to curb rheumatoid arthritis may be a potent foe against another immune disorder, type 1 diabetes.

Australian researchers report that **baricitinib** (Olumiant) appears to help patients newly diagnosed with type 1 diabetes maintain their natural ability to produce insulin, slowing progression of the disease.

Type 1 diabetes comprises about 5% of all diabetes cases. It occurs when the body's immune system mistakenly attacks pancreatic beta cells, which produce insulin.

Without sufficient insulin, people with type 1 diabetes typically require injected hormone to live.

"Up until now, people with type 1 diabetes have been reliant on insulin delivered via injection or infusion pump," explained study lead author **Dr. Thomas Kay**.

However, "our trial showed that, if started early enough after diagnosis and while the participants remained on the [oral] medication, their production of insulin was

maintained," said Kay, a professor at St Vincent's Institute of Medical Research (SVI) in Melbourne.

"People with type 1 diabetes in the trial who were given the drug required significantly less insulin for treatment," he said.

The study, published Dec. 6 in the *New England Journal of Medicine*, is the first human trial focused on baricitinib for type 1 diabetes.

The drug works by blocking an enzyme tied to immune system regulation and inflammation. It appears to reduce the runaway immune response that's responsible for the destruction of pancreatic beta cells.

As Kay explained it, giving the drug to patients early in disease progression is crucial.

"When type 1 diabetes is first diagnosed, there is a substantial number of insulin-producing cells still present," he explained in an SVI news release. "We wanted to see whether we could protect further destruction of these cells by the immune system."

The trial was small -- just 91



people newly diagnosed with type 1 diabetes.

Participants ranged in age from 10 to 30, and all had been diagnosed within 100 days prior to joining the study.

Kay's group tracked their blood sugar levels and insulin production over the course of a year. Patients were randomized to one of two groups: 60 were given baricitinib, while the other 31 received a "dummy" placebo pill. Neither patients nor researchers knew which patients were taking the drug or a placebo.

Participants continued to get their usual insulin therapy throughout the trial.

However, "people with type 1 diabetes in the trial who were given the drug required significantly less insulin for treatment," Kay noted. None of the participants were able to wean themselves off insulin therapy completely, however.

In terms of blood sugar (glucose) control, the researchers said that "baricitinib improved [blood sugar] measures assessed with the use of continuous

glucose monitoring."

Tests also showed that "baricitinib treatment preserved the capacity of [pancreatic] beta-cells to secrete insulin," suggesting slowed progression of the disease, according to the researchers.

Regarding any side effects from the drug, "the frequency and severity of adverse events were similar in the two trial groups, and no serious adverse events were attributed to baricitinib or placebo," Kay's group said.

The study was funded by JDRF (formerly the Juvenile Diabetes Research Foundation).

More study may be needed, but "we are very optimistic that this treatment will become clinically available," said study co-author **Helen Thomas**, also at SVI.

"This would be a huge step-change in how type 1 diabetes is managed, and we believe it shows promise as a fundamental improvement in the ability to control type 1 diabetes," Thomas said.

New Weight-Loss Drug Zepbound Is Now Available, Company Says

The newly approved weight-loss medication known as Zepbound is now available for patients to take, drug maker Eli Lilly announced Tuesday.

"Today opens another chapter for adults living with obesity who have been looking for a new treatment option like Zepbound," Rhonda Pacheco, group vice president of Lilly Diabetes and Obesity, U.S., said in a company [news release](#).

"The availability of Zepbound in U.S. pharmacies is the first step, but we have to work hand-in-hand with employers, government and healthcare industry partners to remove barriers and make Zepbound available to those who need it," Pacheco added. "We are excited to see growing [insurance]

coverage in the marketplace, giving millions of Americans access to Zepbound."

It was only last month when the U.S. Food and Drug Administration [approved](#) Zepbound as a weight-loss medication. Tirzepatide, the active ingredient in Zepbound, had already been approved by the FDA as a treatment for type 2 diabetes called Mounjaro.

To trigger weight loss, tirzepatide mimics two hormones, GLP-1 and GIP, which stimulate the release of insulin in the body. It quiets appetite and slows the rate at which food moves through the stomach, helping patients feel full. Novo Nordisk's weight-loss



medication, Wegovy, uses semaglutide, which only focuses on GLP-1.

That difference translated to greater weight loss with Zepbound than

Wegovy, a recent study found. Zepbound has been [found to prompt up to a 20.9% drop in weight](#) at higher doses, while Wegovy patients typically see a [15% reduction in weight](#).

According to the FDA, Zepbound's most common side effects include nausea, vomiting, constipation and diarrhea.

The drug's label will also have warnings about the potential for inflammation of the pancreas, gallbladder problems, low blood sugar, acute kidney injury, damage to the retina in people with type 2 diabetes, and suicidal

behavior or thinking.

How widely Zepbound will be covered still remains unclear, *CNN* reported. Medicare and Medicaid can't cover obesity medications, but Lilly said it is offering a savings card for people with private insurance to get Zepbound for \$25 for a one- or three-month prescription if their plans cover it. For those whose plans don't cover Zepbound, the savings card would lower the cost to \$550 per month, or roughly half the list price, the company said.

Amid skyrocketing demand for weight-loss drugs, many of these wildly popular drugs have faced supply shortages in recent months.

Folks at High Risk of Heart Disease May Gain From Eating Mackerel, Tuna

Folks with a family history of heart disease might benefit from eating more oily fish like salmon, mackerel, herring and sardines, a new study finds.

Oily fish contain high levels of omega-3 fatty acids, which cannot be produced by the body and must be obtained from the diet.

People's risk of heart disease increased by more than 40% if they had low levels of omega-3 fatty acids plus a family history of heart problems, a large international study concluded.

However, if a person has adequate levels of omega-3 fatty acids, their family heart history increased their risk by just 25%.

The results show that healthy habits can overcome genetic risk in some cases, researchers said.

"The study suggests that those with a family history of cardiovascular disease have more to gain from eating more oily fish than others," said lead researcher [Karin Leander](#), an associate professor of epidemiology at the Karolinska Institute in Sweden.

Omega-3 fatty acids have been linked to a stronger immune system, reduced inflammation, lower blood pressure and improved cholesterol counts, according to the American Heart



Association.

For the study, Leander and her colleagues pooled data from more than 40,000 people,

nearly 8,000 of whom developed heart problems like unstable angina, heart attack, cardiac arrest and stroke.

Levels of omega-3 fatty acids were measured in all study participants. These levels are a reliable measure of a person's dietary intake of oily fish, and more trustworthy than people's self-reported diet data, Leander said.

"The fact that the measurements of fatty acids in blood and tissue are objective, as

opposed to self-reported data on eating habits, is an important advantage," she noted in an institute news release.

Researchers analyzed each person's family history and omega-3 levels, and found that the fatty acids appeared to lower the overall risk for heart disease.

The study was published Dec. 4 in the journal *Circulation*.

"Cardiovascular disease is to some extent hereditary, as shown by twin studies, but it has been difficult to identify the controlling genes," Leander said. "A strong hypothesis is therefore that it is a combination of genetics and environment."

Mind, Body Symptoms Can Precede MS Diagnosis for Years

Patients in the earliest stages of multiple sclerosis might develop certain symptoms that offer an early clue to the degenerative nerve disease, researchers report.

Depression, constipation, urinary tract infections and sexual problems are all more likely in MS patients five years before their official diagnosis, compared with people who never develop MS, researchers found.

Those conditions are also more likely to occur in people with other autoimmune diseases

like lupus or Crohn's disease, results show.

These early signs "would not necessarily lead to earlier diagnosis of the disease in the general population, since these conditions are common and could also be signs of other diseases, but this information could be helpful for people who are at a higher risk of developing MS, such as people with a family history of the disease or those who show signs of MS on brain scans but do not



have any symptoms of the disease," said researcher [Dr. Celine Louapre](#), an associate professor of neurology

at Sorbonne University in Paris.

MS occurs when the immune system attacks the protective sheath that covers nerve fibers, causing progressive interruption of nerve signals between the brain and the body.

For the study, Louapre and her colleagues compared more than 20,000 people newly

diagnosed with MS with nearly 55,000 people who do not have MS. Each MS patient was matched with three healthy people of the same age and sex.

They also compared the MS patients to nearly 30,500 people with Crohn's disease and more than 7,300 patients with lupus.

The researchers specifically reviewed medical records, looking for 113 different diseases and symptoms that the patients might have had in the five years before and after their diagnosis

Cognitive Decline May Come Earlier for People With Epilepsy

People with epilepsy suffer quicker declines in thinking than people without the brain disorder, particularly if they also have risk factors like high blood pressure or diabetes, a new study finds.

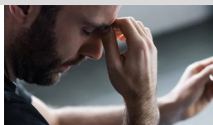
The difference was significant: Over the course of the 14-year study, those with epilepsy experienced a 65% to 70% faster decline in memory and thinking skills.

On top of that, having risk factors for heart disease pushed that percentage 20% higher.

“While epilepsy itself is associated with [mild cognitive

impairment] and dementia, this risk is substantially magnified in those who also have high blood pressure, diabetes or other cardiovascular risk factors,” said lead researcher **Dr. Ifrah Zawar**, an assistant professor of neurology at the University of Virginia in Charlottesville.

Researchers said their study is unique because it tracked the transition to mild cognitive impairment and dementia in more than 13,700 people who started the study with healthy brains.



The participants were recruited at 39 Alzheimer’s disease centers across the United States between September 2005 and December 2021. Fewer than 1% had epilepsy, researchers said.

The rate of decline from mild cognitive impairment to dementia was the same in patients with or without epilepsy. The researchers speculate that’s probably because heart risk factors play a much bigger role than epilepsy in the later stages of dementia.

The findings were presented

Friday at the American Epilepsy Society annual meeting in Orlando, Fla. Such research should be considered preliminary until published in a peer-reviewed journal.

“It is important to identify epilepsy promptly and treat it aggressively, to help slow or prevent this decline in older adults who are cognitively healthy,” Zawar said in a meeting news release. “In addition, early screening and targeted interventions towards modifiable cardiovascular risk factors may also help delay the onset of dementia.”

Some Older Women With Early-Stage Breast Cancer Can Safely Skip Radiotherapy: Study

Women in their 50s and 60s who’ve gone through menopause may be able to safely skip radiation treatment if they’re diagnosed with a common form of breast cancer, new research shows.

The study focused on early stage HR+ breast cancers, which comprise the large majority of new cases. In HR+ breast cancer, tumor cells carry receptors for the hormones estrogen or progesterone.

Typically, postmenopausal women diagnosed with this type of tumor will undergo a lumpectomy, followed by a combination of radiotherapy plus hormonal treatments.

Recent studies have suggested that patients aged 65 and older might do just as well if they skipped radiation treatments, however.

And in this new study, researchers at Emory University in Atlanta found the same might

hold true for even younger postmenopausal women.

“These findings indicate that younger

postmenopausal patients with stage 1 breast cancer who skip radiotherapy after breast-conserving surgery have a very low risk of disease recurrence within five years,” said **Dr. Reshma Jaggi**, chair of radiation oncology at Emory’s School of Medicine and a researcher at the university’s Winship Cancer Institute.

Her team presented the findings Thursday at the annual San Antonio Breast Cancer Symposium (SABCS). The study was also published in the *Journal of Clinical Oncology*.

The Emory trial involved women between 50 and 69 years of age, all of whom had been diagnosed with early stage HR+/HER2- cancers.

HER2- is another hormonal marker for breast tumors;



according to the National Cancer Institute, over 87% of new breast cancer cases are HR+/HER2-.

The research team first gave sensitive genetic tests to each patient, to gauge their tumor’s likelihood of recurrence after lumpectomy.

If a woman’s tests suggested that she faced a low risk of recurrence, she was then given the option to skip radiation therapy but to continue taking five years of hormonal treatments.

The result: Of the 186 patients who could be fully evaluated, 100% were still alive five years after their lumpectomy, and 99% were found to be free of breast cancer at that time.

Based on those results, “younger postmenopausal patients with stage 1 breast cancer who skip radiotherapy after breast-conserving surgery have a very low risk of disease

recurrence within five years,” Jaggi concluded in a SABCS news release.

The jury is still out when it comes to longer term prognosis, however.

“Five years is an early time point for this population, and longer-term follow-up of this study and others will be essential to determine whether this option can be safely offered to women in this age group,” Jaggi stressed.

But she believes the findings can offer women valuable insights when making decisions.

“Studies like this one are important for identifying ways to improve the patient experience, both by identifying multiple treatment options to help patients regain a sense of control that a cancer diagnosis can seem to take away, and by ensuring that all patients are informed and empowered to make the decisions that are right for them,” Jaggi said.

Watching Your Cholesterol? Virtual Doctor Visits Work Just as Well

In a win for telemedicine, new research shows that folks fighting high cholesterol benefit just as much from online coaching as they do from in-person visits with a dietitian.

“This study reinforces the idea that comparable clinical outcomes can be achieved using the virtual format,” said lead researcher **Dr. Shannon Zoulek**, a resident physician at University of Michigan Health.

“Improving cholesterol levels

may reduce cardiovascular events, and having additional options to access treatment will benefit patients who seek treatment,” Zoulek added in a Michigan news release.

More than 20% of American adults are currently using telemedicine, taking their health appointments online rather than traveling to an office, the researchers said in background notes.



For the study, the investigators tracked more than 250 patients seen by a registered dietitian between early 2019 and late 2022 at the Preventative Cardiology Clinic of the University of Michigan’s Frankel Cardiovascular Center.

Around one in five patients opted for a virtual visit, while the rest had face-to-face visits with their dietitian, the researchers said.

Patients who received this diet coaching experienced significant declines in their “bad” LDL cholesterol and triglycerides, both of which decrease the risk of heart disease.

In the end, the researchers found no significant difference in results between telemedicine and in-person visits.

The new study was published recently in the *Journal of Clinical Lipidology*. **Read More**